COLUMBIA UNIVERSITY
IRVING MEDICAL CENTER
Vagelos College of Physicians and Surgeons
College of Dental Medicine

Office of Student
Financial Aid & Planning

630 West 168th Street
Black Building, Room 1-139
New York, NY 10032
212.305.4100 Tel
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www.cumc.columbia.edu/
student/finaid

ACADEMIC YEAR 2020-21

VERIFICATION FORM FOR SIBLING/SPOUSE
ENROLLED IN COLLEGE OR GRADUATE SCHOOL

We are asking the registrars at colleges attended by our students' siblings or spouse to complete this form and return it directly to the Office of Student Financial Planning at Columbia University College of Physicians and Surgeons and the College of Dental Medicine. If we do not receive the form by **SEPTEMBER 30th**, we will assume that the sibling or spouse is not enrolled, and our student's financial aid will be adjusted accordingly.

TO BE COMPLETED BY COLUMBIA UNIVERSITY STUDENT:

Student's Name _____ UNI _____
(Please print or type)

Program & Grad. Year _____

Number of siblings enrolled in college _____

(Note: Complete a separate form for each).

TO BE COMPLETED BY SIBLING/SPOUSE:

Name _____ School ID # _____
(Please print or type)

I authorize _____ to release my enrollment information
(Name of Institution)

to the Student Financial Planning Office at Columbia University.

_____ _____
Signature of Sibling or Spouse Date

TO BE COMPLETED BY SCHOOL FOR THE ABOVE-NAMED SIBLING/SPOUSE:

Student's enrollment status **for 2020-21**

Full-time ☐ Half-time ☐
Part-time ☐ Not Enrolled ☐

Dates of enrollment: From _____ to _____

Expected month/year of graduation: / _____ _____

Degree of certification sought _____

Name and address of school: _____

_____

_____

Signature _____ Date _____

Affix school stamp or seal here.

Name and Title _____ Phone _____

Please return this form to:

Office of Student Financial Planning
College of Physicians & Surgeons
College of Dental Medicine
Columbia University
630 West 168th Street, P&S Box 52-A
New York, New York 10032